NATIONAL HEALTHCARE AGREEMENT

Council of Australian Governments

An agreement between

- the Commonwealth of Australia and
- the States and Territories, being:
  - the State of New South Wales;
  - the State of Victoria;
  - the State of Queensland;
  - the State of Western Australia;
  - the State of South Australia;
  - the State of Tasmania;
  - the Australian Capital Territory; and
  - the Northern Territory of Australia.

The objective of this Agreement is to improve health outcomes for all Australians and the sustainability of the Australian health system.

This Agreement defines the objectives, outcomes, outputs and performance measures, and clarifies the roles and responsibilities that will guide the Commonwealth and States and Territories in delivery of services across the health sector.

National Healthcare Agreement

INTERGOVERNMENTAL AGREEMENT
ON FEDERAL FINANCIAL RELATIONS

PRELIMINARIES

1. This agreement is created subject to the provisions of the *Intergovernmental Agreement on Federal Financial Relations* and should be read in conjunction with that Agreement and subsidiary schedules. In particular, the schedules include direction in respect of performance reporting and payment arrangements.

2. The Parties are committed to addressing the issue of social inclusion, including responding to Indigenous disadvantage. That commitment is embodied in the objectives and outcomes of this agreement. However, the Parties have also agreed other objectives and outcomes - for example, in the National Indigenous Reform Agreement - which the Parties will pursue through the broadest possible spectrum of government action. Consequently, this agreement will be implemented consistently with the objectives and outcomes of all National Agreements and National Partnerships entered into by the Parties.

3. On 20 December 2007, the Council of Australian Governments (COAG) agreed to a reform agenda that will boost productivity, workforce participation and geographic mobility, and support wider objectives of better services for the community, social inclusion, closing the gap on Indigenous disadvantage and environmental sustainability.

4. This National Healthcare Agreement affirms the agreement of all governments that Australia's health system should:

   (a) be shaped around the health needs of individual patients, their families and communities;

   (b) focus on the prevention of disease and injury and the maintenance of health, not simply the treatment of illness;

   (c) support an integrated approach to the promotion of healthy lifestyles, prevention of illness and injury, and diagnosis and treatment of illness across the continuum of care; and

   (d) provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.

5. In this Agreement, all governments agree that the healthcare system will strive to eliminate differences in health status of those groups currently experiencing poor health outcomes relative to the wider community.

6. Governments will seek to make best use of taxpayers' funds, including through developing new, cost-effective approaches and planning for future healthcare needs.

7. The decisions Governments make in operating our healthcare system should be clear and transparent. Australians are entitled to regular reports on the status, quality and performance of all of our healthcare system.

8. All governments will make use of the best available information, will foster innovation and sharing of practices shown to be effective and will work continually, including with others, to improve not only the specific services they provide, but the health of all Australians.

9. The Agreement may be amended at any time in writing by all the Parties and under terms and conditions as agreed by all the Parties.

Scope

10. This Agreement encompasses the collective efforts of Commonwealth, State and Territory governments on prevention, primary and community care, hospital and related care and aged care.

11. Central to this Agreement is a statement of mutually agreed objectives, outcomes and outputs. The Agreement sets out:

    (a) the objectives and expected outcomes and outputs, including a focus on social inclusion and addressing Indigenous disadvantage;

    (b) the role of each jurisdiction, and the responsibilities they undertake to be accountable for;

    (c) the policy and reform directions that will be undertaken to work towards the intended outcomes;

    (d) performance indicators that will inform the community on how governments are progressing towards achieving the stated objectives, outcomes and outputs; and

    (e) performance benchmarks that provide an indication of the standard of service expected or the level of improvement expected in service delivery over a specified period.

STATEMENT OF OBJECTIVES AND OUTCOMES

12. COAG has developed a new integrated approach to improving health outcomes for all Australians and the sustainability of the Australian health system.

Objectives

13. This Agreement identifies the long-term objectives of Commonwealth, State and Territory governments as:

    (a) Prevention: Australians are born and remain healthy;

    (b) Primary and Community Health: Australians receive appropriate high quality and affordable primary and community health services;

    (c) Hospital and Related Care: Australians receive appropriate high quality and affordable hospital and hospital related care;

    (d) Aged Care: Older Australians receive appropriate high quality and affordable health and aged care services;

(e) Patient Experience: Australians have positive health and aged care experiences which take account of individual circumstances and care needs;

(f) Social Inclusion and Indigenous Health: Australia's health system promotes social inclusion and reduces disadvantage, especially for Indigenous Australians; and

(g) Sustainability: Australians have a sustainable health system.

OUTCOMES, PROGRESS MEASURES AND OUTPUTS

14. All parties are accountable to the community for their progress against the agreed outcomes. To assist the community to assess the performance of governments toward achieving these outcomes, the following progress measures and outputs are provided. Reporting requirements under this Agreement should be read in conjunction with provisions in Schedule C of the *Intergovernmental Agreement on Federal Financial Relations*.

15. It is intended that progress measures and outputs will incorporate private sector services where relevant. Where available, information will be collected at the hospital level.

16. The methodology for collecting the progress measures and outputs listed below has been developed with the assistance of the Australian Institute of Health and Welfare. Where further methodological development is required, particularly in relation to new progress measures and outputs, cross-jurisdictional processes will oversight this work.

Outcome	Progress Measure	Output
Prevention		
Children are born and remain healthy. Australians have access to the support, care and education they need to make healthy choices. Australians manage the key risk factors that contribute to ill health.	Proportion of babies born of low birth weight. Incidence/prevalence of important preventable diseases. Risk factor prevalence.	Immunisation rates for vaccines in the national schedule. Cancer screening rates (breast, cervical, bowel). Proportion of children with 4th year developmental health check.

Primary and community health		
The primary healthcare needs of all Australians are met effectively through timely and quality care in the community. People with complex care needs can access comprehensive, integrated and coordinated services.	Access to general practitioners, dental and other primary healthcare professionals. Proportion of diabetics with HbA1c below 7 per cent. Life expectancy (including the gap between Indigenous and non-Indigenous). Infant/young child mortality rate (including the gap between Indigenous and non-Indigenous). Potentially avoidable deaths. Treated prevalence rates for mental illness. Selected potentially preventable hospitalisations. Selected potentially avoidable general practitioner type presentations to emergency departments.	Number of primary care services per 1,000 population (by location). Number of mental health services. Proportion of people with selected chronic disease whose care is planned (asthma, diabetes, mental health). Number of women with at least one antenatal visit in the first trimester of pregnancy.
Hospital and related care		
Australians receive high quality hospital and hospital related care that is appropriate and timely.	Waiting times for services. Selected adverse events in acute and sub-acute care settings. Unplanned/unexpected readmissions within 28 days of selected surgical admissions. Survival of people diagnosed with cancer (5 year relative rate).	Rates of services provided by public and private hospitals per 1000 weighted population by patient type.
Aged care		
Older Australians receive high quality, affordable health and aged care services that are appropriate to their needs and enable choice and seamless, timely transitions within and across sectors.	Residential and community aged care services per 1,000 population aged 70+ years. Selected adverse events in residential care.	Number of older people receiving aged care services by type (in the community and residential settings). Number aged care assessments conducted. Number of younger people with disabilities using residential, CACP and EACH aged care services. Number of people 65+ receiving sub-acute and rehabilitation services. Number hospital patient days by those eligible and waiting for residential aged care.

Patient Experience		
All Australians experience best practice care suited to their needs and circumstances informed by high quality health information. Patients experience seamless and safe care when transferring between settings.	Nationally comparative information that indicates levels of patient satisfaction around key aspects of care they received.	
Social Inclusion and Indigenous Health		
Indigenous Australians and those living in rural and remote areas or on low incomes achieve health outcomes comparable to the broader population.	Age standardised mortality. Access to services by type of service compared to need. Teenage birth rate. Hospitalisation for injury and poisoning. Children's hearing loss.	Indigenous Australians in the health workforce.
Sustainability		
Australians have a sustainable health system that can respond and adapt to future needs.	Net growth in health workforce (doctors, nurses, midwives, dental practitioners, pharmacists). Allocation of health and aged care expenditure. Cost per case mix-adjusted separation for both acute and non acute care episodes.	Number of accredited/filled clinical training positions.

17. All parties to this Agreement agree to provide data for the National Minimum Data Sets listed at Schedule A which may be updated periodically on the agreement of the parties.

ROLES AND RESPONSIBILITIES

18. This Agreement maintains existing roles and responsibilities unless changes are mutually agreed.

19. States and Territories will provide health and emergency services through the public hospital system, based on the following Medicare principles:

    (a) eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided[1] by hospitals;

[1] This Agreement recognises that clinical practice and technology changes over time and that this will impact on modes of service and methods of delivery.

(b) access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and

(c) arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

20. Consistent with these principles, the Commonwealth will continue to subsidise public hospitals and private health services through this Agreement, the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme and other programs.

21. Governments acknowledge that private providers and community organisations play a significant role in delivering health services to the community and will continue to be partners with government in meeting the objectives of this Agreement.

Responsibilities shared by the Commonwealth, States and Territories

22. The Commonwealth, States and Territories will jointly fund:

(a) public hospitals;

(b) public health programs;

(c) mental health services;

(d) sub-acute care;

(e) Aboriginal and Torres Strait Islander health services;

(f) community aged care services;

(g) health research;

(h) health workforce training;

(i) emergency responses[2]; and

(j) blood and blood products.

23. Under this National Healthcare Agreement, the Commonwealth, State and Territory Governments will:

(a) facilitate and implement system reform and regulation where improvements to patient care, safety or patient outcomes can be demonstrated;

(b) collaborate in developing national policy directions and strategic priorities;

(c) regulate the quality and supply of the health workforce;

(d) ensure that all pharmaceuticals are delivered consistent with the National Medicines Policy;

(e) respond effectively to public health emergencies;

(f) co-operate in quality assurance and regulatory activities;

[2] Includes responding to public emergencies and support for emergency air retrieval.

(g) continue to improve health service safety and quality;

(h) collaborate in national food regulatory arrangements;

(i) share and report health system information to ensure continuity of care for patients;

(j) co-operate through agreed governance arrangements for information management and information technology; and

(k) respond positively to any reasonable request for data or information about the utilisation of health services, or the costs of provision of health services, to each other in a timely way.

Responsibilities of States and Territories

24. In addition to their joint funding responsibilities (see clause 22 above), States and Territories will fund:

(a) community health;

(b) capital infrastructure and service planning;

(c) ambulance services;

(d) food safety and regulation; and

(e) environmental health.

25. Under this National Healthcare Agreement, the States and Territories will:

(a) provide public patients with access to all services provided to private patients in public hospitals;

(b) provide service planning, capital works and adequate infrastructure for public hospitals and community health facilities to meet future needs;

(c) provide and fund patient assistance travel schemes and ensure that public patients are aware of how to access the scheme;

(d) ensure that eligible persons who have elected to be treated as private patients have done so on the basis of informed financial consent;

(e) provide and fund pharmaceuticals for public and private inpatients and for public non-admitted patients in public hospitals (except where Pharmaceutical Reform Arrangements are in place);

(f) maintain a Public Patients Hospital Charter and an independent complaints body and ensure that patients are aware of how to access these provisions;

(g) provide public health, community health, Home and Community Care, public dental, deliver vaccines purchased by the Commonwealth under national immunisation arrangements and health promotion programs;

(h) continue to provide agreed national minimum data sets; and

(i) regulate health services and professions and provide clinical training programs for undergraduates and specialists.

Responsibilities of the Commonwealth

26. In addition to its joint funding responsibilities (see clause 22 above), the Commonwealth will fund:

    (a) access to private medical care;

    (b) access to pharmaceuticals;

    (c) access to private health insurance;

    (d) education of health professionals;

    (e) health services for eligible veterans;

    (f) residential aged care services and flexible aged care services;

    (g) purchase of vaccines under national immunisation arrangements; and

    (h) community-controlled Aboriginal and Torres Strait Islander primary healthcare.

27. Under this National Healthcare Agreement, the Commonwealth will:

    (a) seek to ensure equitable and timely access to affordable primary care services, predominantly through general practice;

    (b) assist in reducing pressure on hospital emergency departments through the provision of funding for primary health care services;

    (c) seek to ensure equitable and timely access to affordable specialist services;

    (d) provide reliable, timely and affordable access to safe, cost-effective and high quality medicines;

    (e) ensure that there are sufficient, affordable aged care services so that people needing this care can access it when required, regardless of geographic location;

    (f) regulate the private health insurance industry and subsidise access to private health insurance;

    (g) facilitate access by Aboriginal and Torres Strait Islander people to mainstream health services to help close the health equity gap;

    (h) provide data to the States and Territories on a quarterly basis concerning private health insurance coverage levels, the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme by specified geographic area;

    (i) continue to provide data for agreed national minimum data sets;

    (j) purchase vaccines for delivery by States and Territories through national immunisation arrangements; and

    (k) provide vocational training programs for general practitioners.

PERFORMANCE BENCHMARKS

28. This Agreement will be subject to review as set out in the *Intergovernmental Agreement on Federal Financial Relations*, and in Schedules A, C, D and E to the Intergovernmental Agreement.

29. Improvements in performance will be demonstrated by progress against the following performance benchmarks:

PREVENTION

(a) Reduce the age-adjusted prevalence rate for Type 2 diabetes to 2000 levels (equivalent to a national prevalence rate[3] of 7.1 per cent) within 15 years.

(b) By 2018, reduce the national smoking rate to 10 per cent of the population and halve the Indigenous smoking rate.

(c) By 2017, increase by five percentage points the proportion of Australian adults and Australian children at a healthy body weight, over the 2009 baseline.

HOSPITAL AND RELATED CARE

ADMINISTRATION

(a) Within five years implement a nationally consistent approach to activity-based funding for public hospital services, which also reflects the Community Service Obligations for small and regional hospital services.

EMERGENCY DEPARTMENTS

(a) By 2012-13, 80 per cent of emergency department presentations are seen within clinically recommended triage times as recommended by the Australian College of Emergency Medicine.

QUALITY AND SAFETY

(a) The rate of Staphylococcus aureus (including MRSA) bacteraemia is no more than 2.0 per 10,000 occupied bed days for acute care public hospitals by 2011-12 in each State and Territory.

PRIMARY CARE

(a) By 2014-15, improve the provision of primary care and reduce the proportion of potentially preventable hospital admissions by 7.6 per cent over the 2006-07 baseline to 8.5 per cent of total hospital admissions.

SOCIAL INCLUSION AND INDIGENOUS HEALTH

(a) Close the life expectancy gap for Indigenous Australians within a generation.

(b) Halve the mortality gap for Indigenous children under five within a decade.

[3] For 25 years and over.

POLICY AND REFORM DIRECTIONS

30. The following reform directions have been identified as priority areas for effort over the near-term, noting that the rate of progress in many areas will be contingent on available resources. The foundation for each policy and reform direction is an approach that places the health outcomes of all Australians at the centre of the service system and any reform efforts.

Outcome	Policy directions	Priority reform areas
Prevention		
Children are born and remain healthy. Australians manage the key risk factors that contribute to ill health. Australians have access to the support, care and education they need to make healthy choices.	Increase the focus on prevention through agreed national effort. Encourage public and private investment in initiatives that support children getting a good start in life and people staying healthy, with a focus on disadvantaged groups. Improve surveillance of risk factors and the evidence base to support interventions. Raise self awareness and personal responsibility for health.	Develop a National Preventative Health Strategy. Trial evidence-based approaches to reducing key risk factors contributing to poor health outcomes, including in Indigenous communities. Develop an evidence base to increase efficacy of funding allocations, ensuring appropriate growth in funding over time. Improve access to antenatal and maternal and child health services. Use fiscal and regulatory measures to facilitate and encourage healthy lifestyles.
Primary and Community Health		
The primary healthcare needs of all Australians are met effectively through timely and quality care in the community. People with complex care needs can access comprehensive, integrated and coordinated services.	Encourage patient centred models of primary and community care. Better connect hospitals, primary and community care to meet patient needs, improve continuity of care and reduce demand on hospitals. Improve safety and quality in primary and community care. Use e-health tools to link providers and improve quality of care for the individual.	Develop a National Primary Health Strategy. Enhance the role of primary care practitioners in the early identification and management of patients at risk of chronic disease. Develop a multidisciplinary health workforce in the primary care sector to deliver cost-effective and quality services. Develop a performance benchmark on avoidable hospital presentations to emergency departments.

Hospital and Related Care		
Australians receive high quality hospital and hospital related care that is appropriate and timely.	Reduce waiting times for elective surgery and treatment in emergency departments. Increase the technical efficiency of public hospital services. Improve safety and quality of care and make service performance information available to patients. Provide more effective assessment and support of patients before admission and on discharge from acute care settings.	Move to a nationally consistent approach to activity based funding for services provided at public hospitals. Implement improvements in hospital quality and safety, building on the priorities of the Australian Commission on Safety and Quality in Healthcare. Increase the proportion of elective surgery patients treated within clinically recommended waiting times. Improve access to rehabilitation, post-acute and transition care services. Improve assessment of relative performance of public and private hospitals. Improve quality of data on non-admitted patient services. Improve levels of informed financial consent for private patients in public and private hospitals.
Aged care		
Older Australians receive high quality, affordable health and aged care services that are appropriate to their needs and enable choice and seamless, timely transitions within and across sectors.	Expand appropriate care options commensurate with the needs and aspirations of an ageing population. Provide continuity of care across hospitals, community and aged care to smooth patient transitions. Develop care options for older people with dementia and mental health issues, including aggressive behaviours.	Establish single assessment and information points to streamline care for older people and match care and funding levels to need. Increase access to basic and packaged care in the community. Provide older patients in hospitals with timely access to appropriate sub-acute care including rehabilitation. Reduce numbers of younger people with disabilities in aged care. Improve timely access for eligible older people (including those in hospital) to aged care services and develop an agreed performance benchmark on this measure.

Patient experience		
All Australians experience best practice care suited to their needs and circumstances informed by high quality health information. Patients experience seamless and safe care when transferring between settings.	Develop nationally agreed clinical pathways for key conditions (chronic and complex) and implement and monitor across the health system. Provide accurate, online information on health services with capacity to be customised to individual health needs to support self management. Uphold rights and responsibilities of patients and their carers, including those with mental health needs. Progress an individual electronic health record for all Australians.	Develop and implement patient assessment standards and transfer protocols including for disadvantaged and at risk patients.
Social Inclusion and Indigenous Health		
Indigenous Australian and those living in rural and remote areas or on low incomes achieve health outcomes comparable to the broader population.	Reduce gaps in health outcomes arising from disparities in socio-economic status. Develop innovative evidence based models of care for Indigenous Australians. Improve health services for rural Australia and disadvantaged populations including the homeless. Link health interventions into broader activities designed to redress disadvantage.	Improve access by rural and remote Australians to healthcare through better travel and accommodation, telehealth and workforce initiatives. Expand access to priority health services for the homeless, for Indigenous people and for rural/remote communities. Expand and develop innovative programs for difficult to reach groups, including Indigenous men, socially disconnected young people and the homeless.

Sustainability		
Australians have a sustainable health system that can respond and adapt to future needs.	Build a collaborative approach to evidence based, cost effective practices and policies within and across government and private sectors including investment decisions and clinical care. Improve service delivery through investment in appropriate physical and technological infrastructure. Reward allocative efficiency across preventative, primary, acute care, sub-acute, rehabilitation and aged care services. Invest in research that promotes evidence based practice and innovation.	Move to a proper long-term share of Commonwealth funding for the public hospital system. Increase capacity to train the workforce, including in regional Australia. Support workforce role redesign to ensure most effective and efficient use of available health workforce. Collaborate on action to meet immediate term (five years) health workforce shortages. Engage in collaborative forward planning on capital infrastructure for healthcare services. Engage the Australian community in discussion of what they can reasonably expect from the health system.

PERIODIC REVIEW

31. Policy and reform directions will be reviewed to incorporate evaluations of existing interventions and provide the opportunity to respond to emerging evidence or challenges.

32. A review midway through each four to five year period will be used to consider whether any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies have arisen as a result of the outputs, performance indicators and policy directions.

OTHER ISSUES

33. Business rules governing the operation of this Agreement are at Schedule B.

National Minimum Data Sets

NATIONAL HEALTHCARE AGREEMENT

NATIONAL MINIMUM DATA SETS

A1 This Schedule lists the national minimum data sets (NMDS) that the Parties agree will continue to be collected under this Agreement and which will contribute to the reports listed below.

Name of NMDS	Where is it used (Publication)
Admitted patient care NMDS	Australia's Health Australian Hospital Statistics Report on Government Services State of our Public Hospitals
Admitted patient mental Health Care NMDS	Mental Health Services in Australia Australia's Health Australian Hospital Statistics
Admitted patient palliative care NMDS	Australia's Health Australia's Welfare Australian Hospital Statistics
Alcohol and other drug treatment services NMDS	Alcohol and other drug treatment services in Australia
Community mental Health Care NMDS	Australia's Welfare Mental Health Services in Australia Australia's Health National Mental Health Report
Elective surgery waiting times (census data) NMDS	Australian Hospital Statistics
Elective surgery waiting times (removals data) NMDS	Australia's Health 2008 Australian Hospital Statistics Report on Government Services State of our Public Hospitals
Government health expenditure NMDS	Australia's Health Health Expenditure in Australia Public health expenditure in Australia
Health labour force NMDS	
Mental health establishments NMDS	Australia's Health National Mental Health Report
Non-admitted patient emergency department care NMDS	Australia's Health

	Australian Hospital Statistics Report on Government Services State of our Public Hospitals
Outpatient care NMDS	Australian Hospital Statistics State of our Public Hospitals
Perinatal NMDS	Australia's Health
Public hospital establishments NMDS	Australia's Health Australian Hospital Statistics Report on Government Services State of our Public Hospitals
Residential mental Health Care NMDS 2008-2009	Mental Health Services in Australia Australia's Health National Mental Health Report

A2 There are also a number of longstanding collections essential to the administration, monitoring and evaluation of Breastscreen Australia, the National Cervical Cancer Screening Program, the Needle and Syringe Program and Illicit Drug Diversion Initiative, where National Minimum Data Sets have not yet been developed but where jurisdictions will continue to collect and supply data annually pending these becoming National Minimum Data Sets.

Schedule B

Business Rules for the National Healthcare Agreement

NATIONAL HEALTHCARE AGREEMENT

BUSINESS RULES FOR THE NATIONAL HEALTHCARE AGREEMENT

The following Business Rules are provided to guide States and Territories and service providers in the operation of the National Healthcare Agreement. These rules may be amended at any time with agreement in writing by all the Parties or on behalf of the Parties by the Commonwealth and State and Territory Health Ministers.

Patient Arrangements

B1 Election by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after admission and must be made in accordance with the National Standards for Public Hospital Admitted Patient Election Processes as set out at Appendix C. In particular private patients have a choice of doctor and all patients will make an election based on informed financial consent.

B2 Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms.

B3 Services provided to public patients should not generate charges against the Commonwealth Medicare Benefits Schedule:

(a) except where there is a third party payment arrangement with the hospital or the state/territory, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services;

(b) referral pathways must not be controlled so as to deny access to free public hospital services; and

(c) referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services.

B4 An eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission, the patient will be given the choice to elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient Election processes (unless a third party has entered into an arrangement with the hospital or the state or territory to pay for such services). If it is clinically

appropriate, the hospital may provide information about alternative service providers, but must provide free treatment if the patient chooses to be treated at the hospital as a public patient. However:

(a) a choice to receive services from an alternative service provider will not be made until the patient or legal guardian is fully informed of the consequences of that choice; and

(b) hospital employees will not direct patients or their legal guardians towards a particular choice.

B5 An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

(a) there is a third party payment arrangement with the hospital or the State or Territory to pay for such services; or

(b) the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.

B6 Where a patient chooses to be treated as a public patient, components of the public hospital service (such as pathology and diagnostic imaging) will be regarded as a part of the patient's treatment and will be provided free of charge.

B7 In those hospitals that rely on general practitioners for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted patient services as private patients where they request treatment by their own general practitioner, either as part of continuing care or by prior arrangement with the doctor.

B8 States and Territories which have signed a Memorandum of Understanding with the Commonwealth for the COAG initiative "Improving Access to Primary Care Services in Rural Areas" may bulk bill the Medicare Benefits Schedule for eligible persons requiring primary care services who present to approved facilities.

Veterans

B9 Arrangements for funding and provision of healthcare for entitled veterans are the subject of a separate Commonwealth-State agreement. Nothing in any separate agreement will interfere with the rights of entitled veterans to access public hospital services as public patients in accordance with the National Healthcare Agreement.

Public Patient Charges

B10 Where an eligible person receives public hospital services as a public patient no charges will be raised, except for the following services provided to non admitted patients and, in relation to (f) only, to admitted patients upon separation:

(a) dental services;

(b) spectacles and hearing aids;

(c) surgical supplies;

(d) prostheses – however, this does not include the following classes of prostheses, which must be provided free of charge:

(i) artificial limbs; and

(ii) prostheses which are surgically implanted, either permanently or temporarily or are directly related to a clinically necessary surgical procedure;

(e) external breast prostheses funded by the National External Breast Prostheses Reimbursement Program;

(f) pharmaceuticals at a level consistent with the Pharmaceutical Benefits Scheme statutory co-payments;

(g) aids, appliances and home modifications; and

(h) other services as agreed between the Commonwealth and States and Territories.

B11 Where an eligible person receives Magnetic Resonance Imaging services in a public hospital as an admitted public patient, no charges will be raised against either the patient or the Medicare Benefits Schedule.

Note: Fees may be charged against the Medicare Benefits Schedule for the provision of Magnetic Resonance Imaging services to non-admitted patients, on the condition that those services are provided in accordance with the Health Insurance Act 1973 as amended.

B12 States and Territories can charge public patients requiring nursing care and accommodation as an end in itself after the 35th day of stay in hospital providing they no longer need hospital level treatment, with the total daily amount charged being no more than 87.5 per cent of the current daily rate of the single aged pension and the maximum daily rate of rental assistance.

Charges for Patients other than Public Patients

B13 Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by the State and Territory.

B14 Notwithstanding clause B13, pharmaceutical services to private patients, while they receive services as admitted patients, will be provided free of charge and cannot be claimed against the Pharmaceutical Benefits Scheme.

Pharmaceutical Reform Arrangements

B15 States and Territories which have signed bilateral agreements for Pharmaceutical Reform Arrangements may charge the Pharmaceutical Benefits Scheme for pharmaceuticals for specific categories of patients as provided for in the Arrangements.

Cross Border Adjustments

B16 A mechanism will be agreed between States and Territories to adjust for costs incurred where admitted patient services are provided to eligible persons who are residents of the respective State or Territory.

B17 States and Territories may enter into a bilateral arrangement with other jurisdictions to adjust for costs of non-admitted services of the type covered by this Agreement.

B18 States and Territories agree to work with all other States and Territories to determine and implement appropriate funding and administrative arrangements for Nationally Funded Centres as agreed by Health Ministers.

B19 Any dispute between States and Territories on cross border adjustments will be resolved by referring the matter to an independent person agreed by the disputing States and Territories. In the event that the States or Territories cannot agree on an independent person within eight weeks of one State or Territory seeking the appointment of the independent person, then the matter can be referred by either State or Territory Minister to the Productivity Commission which will appoint an independent person. The independent person will consider material presented by both States and Territories and produce a report recommending an appropriate course of action.

Public Patients' Charter

B20 States and Territories agree to maintain a public patients' hospital charter and an independent complaints body as outlined in Appendix B.

Public Health Programs

B21 The States, Territories and Commonwealth will deliver public health services in accordance with the objectives, principles, roles and responsibilities, and any applicable standards, agreed in relevant national strategies, programs or initiatives.

DEFINITIONS

B22 A reference in this Agreement to the National Health Data Dictionary is a reference to the latest version unless otherwise advised.

B23 A reference in this Agreement to the *Health Insurance Act 1973* or the *National Health Act 1953* is a reference to the Acts as at 1 July 2009 or as amended thereafter.

B24 Words and phrases which are not defined in this Agreement or defined in the Health Insurance Act 1973 are to be given their natural meaning.

B25 In this Agreement, unless otherwise specified, words and phrases are to be interpreted as follows.

Admitted patient	Means, "Admitted patient" as defined in the National Health Data Dictionary. *Note: All newborn days of stay (patient is aged 9 days or less) are further divided into categories of qualified and unqualified for NHCA and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn meets at least one of the following criteria:* • *is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;* • *is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for Health for the purpose of the provision of special care; remains in hospital without its mother; Is admitted to the hospital without its mother.* *Acute (qualified) newborn days are eligible for health insurance benefit purposes and should be counted under the NHCA. Days when the newborn does not meet these criteria are classified as unqualified (if they are nine days old or less) and should be recorded as such. Unqualified newborn days should not be counted under the NHCA and are not eligible for health insurance benefit purposes.*
Admitted patient services	Means services of the kind defined in the National Health Data Dictionary, relating to "Care Type" provided to an admitted patient during an episode of care (admitted care).
Commonwealth Minister	Means the Commonwealth Minister for Health and Ageing or any other Commonwealth Minister who administers matters to which this Agreement relates, and includes any other Commonwealth Minister who may be acting for and on behalf of any of those Ministers.
Compensable patient	Means an eligible person who is: • receiving public hospital services for an injury, illness or disease; and

	• entitled to receive or has received a compensation payment in respect of an injury, illness or disease; or if the individual has died – the individual's estate, provided that the order under sub-section 6(2) of the *Health Insurance Act 1973*, dated 11 January 1984 remains in force, or a replacement order remains in force. *Note: The order referred to above excludes compensable patients from eligibility for Medicare in relation to public hospital services related to the compensable injury, illness or disease.*
Complaints body	Means an independent entity established or commissioned to investigate complaints and/or grievances against providers of States and Territories's public hospital services.
Eligible person	Means, as defined in subsection 3(1) (6) (6A) and (7) of the *Health Insurance Act 1973*.
Emergency department	Means the dedicated area in a hospital that is organised and administered to provide a high standard of emergency care to those in the community who perceive the need for, or are in need of acute or urgent care, including hospital admission.
Entitled veteran	Means a Department of Veterans' Affairs patient referred to in the *Veterans' Entitlements Act 1986*.
Ineligible person	Means any person who is not an eligible person.
Mental Health services	Means the services as defined in the latest agreed National Mental Health Plan.
National Health Data Dictionary	Means the publication (in hard copy and/or the internet) containing the Australian National standard of data definitions recommended for use in Australian health data collections; and the National Minimum Data Sets agreed for mandatory collection and reporting at a national level.
Non-admitted patient services	Means services of the kind defined in the National Health Data Dictionary, under the data element "Non-Admitted Patient Service Type".
Outpatient department	Means any part of a hospital (excluding the Emergency department) that provides non-admitted patient care.
Patient election status	Means the status of patients as determined in line with clause B1 according to the National Standards for Public Hospital Admitted Patient Election Processes in Appendix C.
Pharmaceutical Benefits Scheme	Means the Commonwealth government's scheme to provide subsidised pharmaceuticals to Australians established under part VII of the *National Health Act 1953* (the Act) together with the National Health (Pharmaceutical Benefits) Regulation 1960 made under the Act.
Pharmaceutical Reform Arrangements	Means arrangements which provide for public hospitals that are Approved Hospital Authorities under Section 94 of the *National Health Act 1953* to supply pharmaceuticals funded by the PBS for specific categories of patients including: • admitted patients on separation; • non-admitted patients; and • same day admitted patients for a range of drugs made available by specific delivery arrangements under Section 100 of the *National Health Act 1953*.
Public hospital services	Means health and emergency services of a kind or kinds that are

	currently or were historically provided by hospitals that are wholly or partly funded by a State or Territory. This agreement recognises that clinical practice and technology change over time and that modes of service of methods of delivery will change over time.
Public patient	Means an eligible person who receives or elects to receive a public hospital service free of charge.
Public patients' hospital charter	Means the document outlining how the principles of this Agreement are to be applied; the process by which eligible persons might lodge complaints about the provision of public hospital services; a statement of rights and responsibilities of consumers and public hospitals; and a statement of consumers' rights to elect to be treated as either public or private patients.
Separation	Means "Separation" as defined in the National Health Data Dictionary.
State Minister	Means the State Minister for Health or any other State Minister who administers, for the State, matters to which this Agreement relates, and includes any other State Minister who may be acting for and on behalf of any of those State Ministers.
Third party	Means any party other than the Commonwealth (including Department of Veterans' Affairs) and the State Department administering the Agreement that enters into an arrangement for the purchase of public hospital services.

PUBLIC PATIENTS' HOSPITAL CHARTER AND COMPLAINTS BODY

Background

B26 Under Schedule D of the 1998-2003 Australian Health Care Agreements all States agreed to:

(a) review and update Public Patients' Hospital Charters, develop them in appropriate community languages and develop and implement strategies for distributing them to users of public hospital services; and

(b) maintain complaints bodies independent of the public hospital system to resolve complaints made by eligible persons about the provision of public hospital services received by them.

Public Patients' Hospital Charter

B27 States and Territories agree to:

(a) review and update the existing Public Patients' Hospital Charter (the Charter) to ensure its relevance to public hospital services. The review should be conducted with the Australian Commission for Safety and Quality in Health Care or any successor;

(b) develop the Charter in appropriate community languages and forms to ensure it is accessible to people with disabilities and from non English speaking backgrounds;

(c) develop and implement strategies for distributing the Charter to public hospital service users and carers; and

(d) adhere to the Charter.

B28 States and Territories agree to the following minimum standards:

(a) the Charter will be promoted and made publicly available whenever public hospital services are provided; and

(b) the Charter will set out:

(i) how the principles in Clause 19 of this National Healthcare Agreement are to apply to the provision of public hospital services in States and Territories;

(ii) the process by which eligible persons can lodge complaints about the provision of public hospital services to them;

(iii) complaints may be referred to an independent complaints body;

(iv) a statement of the rights and responsibilities of consumers and public hospitals in the provision of public hospital services in States and Territories and the mechanisms available for user participation in public hospital services; and

(v) a statement of consumers' rights to elect to be treated as either public or private patients within States and Territories' public hospitals, regardless of their private health insurance status.

Independent Complaints Body

B29 States and Territories agree to maintain an independent complaints body to resolve complaints made by eligible persons about the provision of public hospital services to them.

B30 States and Territories agree to the following minimum standards:

(a) the complaints body must be independent of bodies providing public hospital services and States and Territories' health departments;

(b) the complaints body must be given powers to investigate, conciliate and/or adjudicate on complaints received by it; and

(c) the complaints body must be given the power to recommend systemic and specific improvements to the delivery of public hospital services.

B31 The Commonwealth and States and Territories agree that the powers of the complaints body will not interfere with or override the operation of registration boards or disciplinary bodies in States and Territories and that the exercise of powers by the complaints body will not affect the rights that a person may have under common law or statute law.

B32 To assist in making recommendations and taking action to improve the quality of public hospital services, States and Territories agree to implement a consistent national approach, agreed with the Australian Commission for Safety and Quality in Healthcare or any successor, to collecting and reporting health complaints data to improve services for patients.

NATIONAL STANDARDS FOR PUBLIC HOSPITAL ADMITTED PATIENT ELECTION PROCESSES

B33 In accordance with this Agreement, public hospital admitted patient election processes for eligible persons should conform to the following national standards:

Admitted Patient Election Forms

B34 Admitted Patient election forms can be tailored to meet individual State, Territory or public hospital needs. However, as a minimum, forms should include:

(a) a statement that all eligible persons have the choice to be treated as either public or private patients. A private patient is a person who elects to be treated as a private patient and elects to be responsible for paying fees of the type referred to in Schedule B clause B13 of this National Healthcare Agreement;

(b) a private patient may be treated by a doctor of his or her choice, and may elect to occupy a bed in a single room. A person may make a valid private patient election in circumstances where only one doctor has private practice rights at the hospital. Further, single rooms are only available in some public hospitals, and can not be made available if required by other patients for clinical reasons. Any patient who requests and receives single room accommodation, must be admitted as a private patient; *(Note: eligible veterans are subject to a separate agreement)*

(c) a statement that a patient with private health insurance can elect to be treated as a public patient;

(d) a clear and unambiguous explanation of the consequences of public patient election. This explanation should include advice that admitted public patients (except for care and accommodation type patients as referred to in Schedule B clause B12):

(i) will not be charged for hospital accommodation, medical and diagnostic services, prostheses and most other relevant services; and

(ii) are treated by the doctor(s) nominated by the hospital;

(e) a clear and unambiguous explanation of the consequences of private patient election. This explanation should include advice that private patients:

(i) will be charged at the prevailing hospital rates for hospital accommodation (whether a shared ward or a single room), medical and diagnostic services, prostheses and any other relevant services;

(ii) may not be fully covered by their private health insurance for the fees charged for their treatment and that they should seek advice from their doctor(s), the hospital and their health fund regarding likely medical, accommodation and other costs and the extent to which these costs are covered; and

(iii) are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital;

(f) evidence that the form was completed by the patient or legally authorised representative before, at the time of, or a soon as practicable after, admission. This could be achieved by the witnessing and dating of the properly completed election form by a health employee;

(g) a statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforseen circumstances include, but are not limited to, the following:

(i) patients who are admitted for a particular procedure but are found to have complications requiring additional procedures;

(ii) patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate healthcare professional; and

(iii) patients whose social circumstances change while in hospital (for example, loss of job);

(h) in situations where a valid election is made, then changed at some later point in time because of unforeseen circumstances, the change in patient status is effective from the date of the change onwards, and should not be retrospectively backdated to the date of admission;

(i) it will not normally be sufficient for patients to change their status from private to public, merely because they have inadequate private health insurance cover, unless unforeseen circumstances such as those set out in clause B34(g) of this Appendix apply;

(j) a statement signed by the admitted patient or their legally authorised representative acknowledging that they have been fully informed of the consequences of their election, understand those consequences and have not been directed by a hospital employee to a particular decision;

(k) a statement signed by admitted patients or their legally authorised representatives who elect to be private, authorising the hospital to release a copy of their admitted patient election form to their private health insurance fund, if so requested by the fund. Patients should be advised that failure to sign such a statement may result in the refusal of their health fund to provide benefits; and

(l) where admitted patients or their legally authorised representatives, for whatever reason, do not make a valid election, or actual election, these patients will be treated as public patients and the hospital will choose the doctor until such time as a valid election is made. When a valid election is made, that election can be considered to be for the whole episode of care, commencing from admission.

Multiple and Frequent Admissions Election Forms

B35 A State, Territory or hospital may develop a form suitable for individuals who require multiple or frequent admissions. The form should be for a specified period, not exceeding six months, and nominate the unit where the treatment will be provided. Further, the form should be consistent with the national standards and provide patients with the same information and choices as a single admission election form.

Other Written Material Provided to Patients

B36 Any other written material provided to patients that refers to the admitted patient election process must be consistent with the information included in the admitted patient election form. It may be useful to include a cross reference to the admitted patient election form in any such written material.

Verbal Advice Provided to Patients

B37 Any verbal advice provided to admitted patients or their legally authorised representatives that refers to the admitted patient election process must be consistent with the information provided in the admitted patient election form.

B38 Admitted patients or their legally authorised representatives should be referred to the admitted Patient election form for a written explanation of the consequences of election.

B39 To the maximum extent practicable, appropriately trained staff should be on hand at the time of election, to answer any questions admitted patients or their legally authorised representatives may have.

B40 Through the provision of translation/interpreting services, hospitals should ensure, where appropriate, that admitted patients, or their legally authorised representatives, from non-English speaking backgrounds are not disadvantaged in the election process.